SECTION 2

PODIATRIC SERVICES

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1 PODIATRIC SERVICES

The purpose of the podiatry program is to increase the functioning ability of the Medicaid recipient.

Podiatric services include the examination, diagnosis and treatment of the human foot through medical, mechanical or surgical means. Services may be performed by a physician, osteopath, or podiatrist as specified by the respective professional license.

Podiatric service may be provided to a Medicaid recipient who has a foot problem that causes:

1. difficulty walking or inability to walk;
2. painful or distressing impairment which limits independent function; or
3. crippling.

Medicaid covers the podiatric services described for children from birth through age 20 and for pregnant women. For dates of service on or after July 1, 2002, Medicaid does NOT cover podiatric services to non-pregnant adults age 21 and older.

1 - 1 Client Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan, such as a health maintenance organization (HMO), must receive all health care services through that plan. Refer to SECTION 1, Chapter 5, *Verifying Eligibility*, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1,Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Client NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Co-payment Requirement for Non-pregnant Adults

Effective November 1, 2001 through June 30, 2002, many non-pregnant adult Medicaid clients will be required to make a $2.00 co-payment for office visits performed by a podiatrist. Services include those performed in a Federally Qualified Health Center (FQHC). Both HMO and fee-for-service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-payment is required and for what type of services. The provider is responsible to collect the co-payment at the time of service or bill the client. The amount of the client's co-payment will automatically be deducted from the claim reimbursement. Requirements specific to podiatric services are stated below.

For general information about the co-payment requirement, clients required to make a co-pay, exempt clients, and an example of the co-payment message on the Medicaid Identification Card, refer to SECTION 1 of this manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments.

A. Clients Exempt from Co-payments

If there is not a co-payment message under a client's name, the client does not have a co-payment. Also, do not require a co-payment for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

B. Co-payment per Medical Visit

Except for exempt clients described in item A, Medicaid clients have a $2.00 co-payment for podiatric visits.

2 DEFINITIONS

The "practice of podiatry" means the examination, diagnosis, or treatment medically, mechanically or surgically of the ailments of the human foot. In accordance with Utah Code Annotated 58-5-1, the practice of podiatry is limited to the human foot.

A "prosthetic device" means a replacement, corrective or supportive device prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to:

A. artificially replace a missing portion of the body;
B. prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning); or
C. support a weak or deformed portion of the body.

3 COVERED SERVICES

Covered podiatric services are limited to examination, diagnosis, and treatment described in this chapter.

3 - 1 Podiatric Services

Podiatric services include the following:

- Foot incision
- Foot excision
- Repair, revision or reconstruction
- Nail treatment, subject to limitations described in Chapter 4, Limitations.
- Radiology
- Reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendinitis, and other related conditions that result from, or are associated with, partial displacement of foot structures.
- Surgical correction in the subluxated foot structure only when it is an integral part of the treatment of a foot injury.
- Surgical correction undertaken to improve the function of the foot or to alleviate an associated symptomatic condition is also a covered service.
- Medical supplies and materials used by the podiatrist over and above those usually included for the surgical procedure.

3 - 2 Shoes and Shoe Repair

A. Shoes are a Medicaid benefit only when:
   (1) attached to a brace or prosthesis; or
   (2) especially constructed to provide for a totally or partially missing foot. The previous amputation must be documented and diagnosis of diabetes with previous foot ulcerations.

B. Shoe repair is covered only when it relates to external modification of an existing shoe to meet a medical need, for example, leg length discrepancy requiring a shoe build up of one inch or more;

4 LIMITATIONS

Limitations which apply to services provided by a physician or osteopath also apply to services provided by a podiatrist.

1. Treatment of a fungal (mycotic) infection of the toenail is covered if there is documented clinical evidence of mycosis that causes limitation of ambulation or pain.

2. A person licensed to practice podiatry may not administer general anesthesia and may not amputate the foot.

3. Palliative care must include the specific service and must be billed by the specific service and not by using an evaluation and management (office call) procedure code.

5 NON-COVERED SERVICES

Any service not listed as covered is not a Medicaid benefit. The following services are not covered:

1. Preventive maintenance, routine foot care, ordinarily within the realm of self care or nursing home care considered to be routine is not a benefit. This includes:
   A. The removal of corns, warts or callouses unless a danger to the patient exists (for example: diabetes, arteriosclerosis or Buerger's disease).
   B. The trimming, cutting, clipping, or debriding of nails (including mycotic nails).
   C. Other hygienic and preventive maintenance care, such as cleaning and soaking of the feet, the use of massage or skin creams to maintain skin tone of either ambulatory of bedfast patients, and any other service performed in the absence of localized illness or injury.
   D. Any application of topical medication or any treatment of fungal (mycotic) infection of the toenail, except when there is limitation to ambulation or pain.

2. Supportive devices including arch supports or orthotics are not a benefit.

3. Treatment and evaluations of subluxation or flat feet is not a benefit.
   A. The treatment, including evaluation, of subluxations of the feet. These are structural misalignments, or partial dislocation (other than fractures or complete dislocations) of the joints of the feet which require treatment only by nonsurgical methods regardless of underlying pathology.
   B. The treatment, including evaluations and the prescriptions of supporting devices, of the local condition of flattened arches regardless of the underlying pathology.

4. Shoes, orthopedic shoes or other supportive devices for the feet, except when shoes are integral parts of leg braces or prosthesis are not benefits.

5. Special shoes such as the following are not benefits:
   A. Mismatched shoes (unless attached to a brace);
   B. Shoes to support an overweight individual;
   C. Trade name or brand name shoes considered "orthopedic" or "corrective";
   D. "Athletic" or "walking" shoes;

4. Shoe repair except as it relates to external modification of an existing shoe to meet a medical need is not a benefit.

5. Internal modification of a shoe is not a benefit.

6. A person licensed to practice podiatry may not administer general anesthesia and may not amputate the foot.

6 PODIATRIC SERVICES FOR RESIDENTS OF A LONG TERM CARE FACILITY

1. Medicaid recipients who reside in a nursing home or long term care facility may receive benefits from the podiatry program as indicated in covered services.

2. Limitation of Service for Residents of a Long Term Care Facility.
   A. Foot care which may be performed by an employee of the facility is not a Medicaid benefit.
   B. Foot care is limited to one visit every two months. Services in excess of this standard require prior authorization.
   C. The debridement of mycotic toenails is limited to once every 60 days. Services in excess of this standard require prior authorization. (See limitations in Chapter 4)
   D. Trimming corns, warts, callouses or nails is limited to once every 60 days for patients with diabetes, arteriosclerosis, or Buerger's Disease. Services in excess of this standard require prior authorization.
   E. Payment for nursing home visits (Evaluation and Management) is not a benefit. Only the services preformed can be billed.

3. Surgical procedures on Medicaid recipients who reside in a nursing home are subject to post payment review. Recovery of payment will be made if the service was not appropriate.

7 PRIOR AUTHORIZATION

Some services, particularly surgical services, require the podiatrist to obtain prior authorization from Medicaid before service is provided. All requests for prior approval must be made before the surgery or service is performed, except for recipients made retroactively eligible for Medicaid.

The only exceptions to obtaining prior authorization before service is provided are in life threatening or justifiable emergency situations. Refer to SECTION 1, Chapter 9, Prior Authorization Process, for additional information.

7 - 1 Prior Authorization Requests

Prior authorization requests must include the following information:
A. the diagnosis and the severity of the condition;
B. the prognosis;
C. the expected independence of the recipient or benefit of the procedures;
D. the procedure code(s);
E. the patient x-rays (if applicable);
F. adequate clinical assessment of patient needs.

7 - 2 Services to Residents of a Long Term Care Facility Which Require Prior Authorization

A. **Prior authorization is required** for the debridement of mycotic toenails when required more frequently than once every 60 days.
B. **Prior authorization is required** if trimming corns, warts, callouses or nails is performed for any patient with diabetes, arteriosclerosis, or Buerger's Disease, when required more frequently than every 60 days.

8 REIMBURSEMENT FOR PODIATRY SERVICE

The procedure codes in the attached list are reimbursable by Medicaid to podiatrists. Procedure codes which may be billed are identified by CPT codes found in the Health Common Procedure Coding System (HCPCS).

1. Evaluation and Management visits

   Evaluation and Management visits are not designated by the time involved but by the service provided. The CPT identifies the elements and services included in each level of office visit or home visit. All evaluation and management visits shall not be billed in addition to a service.

2. Palliative care must include the specific service and must be billed by the code for the specific service and not by a code for an office call.

Podiatry Codes Covered by the Utah Medicaid Program

Injection Procedure Codes

J0670	injection, mepivicaine
J0690	injection, cefazolin sodium, up to 500 mg
J0696	injection, ceftrizxone Sodium, per 250mg
J0810	injection, cortisone, up to 50 mg
J1100	injection, dexamethasone, sodium phos
J2000	injection, lidocaine Hcl
J2175	injection, meperidine Hcl, Per 100 mg
J2920	injection, methylprednisolone sodium
J2970	injection, methicillin sodium, up to 1 gm
J3301	injection, triamicinolone acetonide
J3302	injection, triamicinolone diacetate

CPT Codes

CPT Codes	
10060	incision and drainage of abcess, simple
10061	incision and drainage of abcess, complex
11000	debrd extnsv, exem/infct skin <10% bdy
11040	debredment; skin, partial thickness
11041	debredment; skin, full thickness
11042	debredment; skin & subcutaneous tissue
11043	debredment; skin, part.thick;subcut.tissue
11055	paring/cutting be. les. (corn or callous)
11056	paring/cutting be. lesions
11057	paring/cutting be. lesions
11100	biopsy, skin, subcut tissue/mucous mem
11420	exc ben les/ lgs, ft >0.5 cm
11421	exc ben les/ lgs, ft .6-1cm
11422	exc ben les/ lgs, ft 1.1-2cm
11719	Trim nondystrophic nails, any number
11720	debredment of nails, by any method; on
11721	debredment of nails, by any method; si
11730	avulsion nail plate, single
11732	avulsion nail plate, each additional

CPT Codes	
11740	evac of subungual hematoma (nail)
11750	exc nail & matrix, partial or complete
11752	exc nail, with amp of tuft distal phalanx
11755	Bipsy of nail unit, any method
11760	Repair of nail bed
11762	Reconstruction of nail bed with graft
11765	Wedge Exc nail fold, (ingrown nail)
12001-12004	Simple Wound Repair
17000	Destructions benign lesion any method
17003	Dest benign 2nd to 14 lesions any method
17004	Dest benign lesions 15 or more
17110	destruct, any meth, warts mollus, milia,
17111	. . . . . 15 more lesions
17250	chemical cauterization of granulation tis
20550	injec, tendon sheath, ligmt/trigger pt
20600	arthocentesis, asp/injec, small joint
20670	removal wire, pin screw superficial
27630	exc. lesion tend, sheath or capsule ankle
27647	Partial exc, bone talus or calaneus
27695	repair, primary, disrupted lig. Anke; coll
27696	prim suture both collateral ligament ank
27698	repair, second distrupted lig, ankle, colla

Codes in **bold** print are newly added to this list.

CPT Codes	
27760	closed trmt medial malleaolus fracture
27762	close trmt medial malleaolus fx: manip
28001	incision and drainage, bursa, foot
28002	incision and drain, with or without tend sheath
28003	multiple areas
28005	incision bone cortex, foot
28008	fasciotomy, foot and or toe
28010	tenotomy, percutaneous, toe; single tend
28011	tenotomy, percutaneous, toe; mulitple
28020	arthrotomy explor, drain, remvl foreign
28022	arthort w/explr. drain, metatarsophalang
28024	arthrot w. epxlr, drain, interphalang toe
28030	neurectomy, intrinsic musculature of foot
28035	release, tarsal tunnel (post tibial nerve)
28043	excision, tumor foot, subcutaneous tiss.
28045	deep subfacial, intramuscular
28050	arthotomy w. biopsy interater/ tarsosme
28052	arthotomy for bio, metatarsophalangeal
28054	arthotomy for bio, interphlangeal joint
28060	fasciectomy, plantar fascia, partial
28062	exc plant fascia part radical, indep prokl

CPT Codes	
28070	synovectomy, intertarsal/tarsometatarsal
28072	synovectomy metatarsophalgea
28080	excision, interdigital (morton) neuroma,
28086	synovectomy, meta tarsophalalngeal
28088	extensor
28090	excision lesion, tendon, tendon sheath
28092	. . . toes
28100	to exc/curt bn cyst ben tum, astracl
28104	exc/curett bone cyst/tum, tarsal/metatars
28108	exc/curett bone cyst/benign tum, phalang
28110	part exc.5th metatarsal
28111	ostectomoy, comp excision, 1st metatarsl
28112	ostectomy, 2,3,4, metatarsal heads
28113	ostectomy, 5th metatarsal head
28114	ostectomy, complex; metatarsl head, excl
28116	excision tarsal coalition
28118	ostectomy, calcaneus
28119	ostectomy, for spur
28120	partial excision bone; talus or calcaneus
28122	partial excision bone; tarsal or metatarsal
28124	partial excision, bone; phalanx of toe
28126	resection, part or comp, phalan base, toe

CPT Codes	
28140	metatarsectomy
28150	phalangectomy, toe, each toe
28153	resection, condyles, distal end phalanx
28160	hemiphalangectmy/interphalng joint exc,
28171	radical resection tumor, bone; tarsal
28173	radical resection of tumor, bn metatarsal
28175	radical resection of tumor, bn phalanx toe
28190	remove foreign body; subcutaneous
28192	deep
28193	complicated
28200	repair, tendon, flex, foot, prim sec, w/o
28220	tenolysis, flexor, foot; single tendon
28222	tenolysis, flexor, foot; multiple tendons
28225	tenolysis, extensor, foot; single tendon
28226	tenolysis, extensor, foot; multiple tendon
28230	tenotomy, open, tend flexor; ft, sg or mul
28232	tenotomy, open tendon, flexor; toe, single
28234	tenotomy, open, extensor, foot or toe, each
28238	reconstruc, post tibilal tend with exc navicular bone
28270	capsulotomy, metatarsphal joint, with or without ten
28272	capsulotomy; interphalangeal joint, each joint

CPT Codes	
28280	Syndactylization toes (kelikian proc)
28285	correction, hammertoe
28286	correction, cock-up fifth toe, with plastic sk
28288	ostectomy, part, exostec/condylectomy
28289	hallux rigidus corr, first metatarsal joint
28290	corr, hallux valgus with or without sesamoidecto
28292	ostectomy, keller, mcbride, mayo type
28293	arthroplsty metatarsal w/resct/implnt j
28296	arthoplasty metatarsal with osteotomy
28298	bunion correction; by phalnx osteotomy
28299	by other methods (eg. double osteotomy)
28307	ostectomy, with or without lght, short, with graft
28308	ostectomy, with or without lgth, short met; other
28309	ostectomy, with or without lgth, short, multiple
28310	ostectomy, shor, angul/rotat corr; 1st phal
28312	ostectomy, os calcis, oth phalang, any toe
28313	reconstructioin, angulr deformity toe, soft
28315	sesmoidectomy, first toe (separate proc)
28320	repair, nonunion or malunion; tarsal bone
28322	repair, non/malunioin metatarl with or without graf
28340	reconstruct toe macrdactyly; soft tiss
28344	recontruct toes; polydactyly
28345	recontruct, syndactyly, with or without graft
28505	Open treatment of fracture of great toe, phalanx, phalanges, with or without fixation
28510	Closed treatment of fracture, phalanx or phalanges other than great toe, without manipulation
28515	Closed treatment of fracture, phalanx or phalanges other than great toe, with manipulation

Codes in **bold** print are newly added to this list.

CPT Codes	
29405	application short leg cast (below knee-toes)
29425	walking or ambulatory type cast
29450	appl club foot cast/mldng/manip, lg/sh
29550	strapping, toes
29580	unna boot
64450	nerve block oth peripherl nvrs or branch
99070	supplies & materials over ususal off visit
99202	office/outpat visit new
99212	office/outpat visit established patient
99242	office consultation new/establ patient
99252	initial inpatient consultation

Radiologic Procedures

73600	radiologic exam, ankle; ant/post/lat view
73610	rad exam, ankle; complete, min 3 views
73620	rad exam, foot; ant/post/lat view
73630	rad exam, foot; complete, min 3 views
73650	rad exam, calcaneous; min 2 views
73660	rad exam, toe or toes, min 2 views

Miscellaneous

A4570	splint
A4580	cast supplies
A4590	special cast material (eg fiberglass)
Y8025	office surgery kit

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